Claim For Continuing Compensation On Account Of Disability

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Statement of Injured Employee - See Instructions on Reverse Side. The requested information is required to obtain a benefit (5 USC 8101 et. seq.)

OMB No. 12150103
Expires: 10-31-99

1. Name of Injured Employee (Last, first, middle)

2. OWCP File Number, if known

3. Home Mailing Address (Include zip code)

4. Social Security Number

5. Date and Hour of Injury (Mo., day, year)
☐ AM
☐ PM

6. Period Compensation is Claimed As A Result of Pay Loss (Mo., day, year) If pay loss was intermittent attach separate sheet showing dates and hours of pay loss.
From: Through:

7. Have you received any leave pay during the period shown in item 6?
☐ Yes ☐ No Show Inclusive Dates. From: Through:
If leave use was intermittent, attach separate sheet showing dates and hours used.

8. Do you wish to repurchase leave?
☐ Yes ☐ No

9. Complete this item if you worked anywhere during the period shown in item 6. Attach a separate sheet if needed.

a. Salaried Employment

Dates & Hours Worked	Pay Rate (Per hour, day or week)	Total Amount Earned	Type Work Performed	Name & Address of Employer

b. Commission and Self-Employment. Show all activities, whether or not income resulted from your efforts.

Dates & Hours Worked	Name & Address of Business	Self-Employed ☐ Commission ☐	Type of Activity Performed	Income Derived (Attach Explanation If Needed)

10. If you were only partially disabled and did not work, state reason for not working.

11. If, since filing your initial claim for compensation, you have applied for or received VA Benefits based on Military Service for the United States, give the following:

Claim No. | Date of Disability and Monthly Payment | Name & Address of Office Where Claim Is Filed

12. If, since filing your initial claim for compensation, you have applied for or received an annuity under the Civil Service Retirement Act or other Federal retirement or disability law, give the following:

Claim No. | Amount of Monthly Payment | Name & Address of Office Where Claim Is Filed

13. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

14. Date (Mo., day, year)

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

Statement of Official Supervisor

15. If employee has returned to work, show date and hour (Mo., day, year)

☐ AM
☐ PM

16. Show employee's work week on return to duty, if other that Monday thru Friday

☐ S	☐ M	☐ T	☐ W	☐ T	☐ F	☐ S

17. Has employee received any pay for work, leave, subsistence, quarters or other renumeration from your agency during the period shown in item 6 on the reverse side?

☐ Yes ☐ No

18. If the answer to item 17 is Yes, show:

Amount: $

Type of Payment:

Period: From: _____ Through: _____

19 If there has been any change in employee's health benefit enrollment and/or optional insurance since previous claim for compensation was submitted, please explain. (i.e. change of plan or option; if additional deductions have been made by the agency, show amount and period.)

20. Remarks

21. A supervisor who knowingly certifies to any false statement misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

22. Signature of Official Superior	23. Title	24. Date (mo., day, year)

Instructions for injured Employee

a. Items 1 through 14 on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by OWCP. Forms may be obtained from OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $10,000, or imprisonment for not more than five years, or both.

d. The employee is responsible for submitting, or arranging for the submission of medical evidence in support of this claim. The CA-ma is attached to form CA-8 for this purpose. The employee should complete items 1 - 6 on form CA-20a. The attending physician should complete items 7 through 23. The address of the appropriate OWCP office should be entered in item 3 on the reverse of the CA-i0a.

Instructions for Official Superior

a. The official superior must complete items 15 through 24 and forward the form, and any accompanying medical report, to the appropriate OWCP office, within 5 working days of receipt from the employee.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

Note: Failure to submit this form properly completed with supporting medical evidence will delay payment of compensation.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Submit Cancel